New Jersey Department of Children and Families Policy Manual

Manual:	CP&P	Child Protection and Permanency	Effective Date:
Volume:	V	Health Services	
Chapter:	A	Health Services	11-20-2001
Subchapter:	3	Medicaid Services	
Issuance:	100	**Services Authorized Through Medicaid**	

Authorized Services **5-23-95**

Payments of medical assistance are authorized for the following health services:

Chiropractic Service	Nursing Facility Services, including Intermediate Care
Dental Services	Facilities for the developmentally disabled
Early Periodic Screening, Diagnosis and Treatment	Nurse-midwifery Services
Family Planning	Optical Appliances
Healthstart	Optometric Services
Hearing Aid Services	Outpatient Hospital Services
Hospice Services	Pharmaceutical Services
Inpatient Hospital Services	Physician Services
Inpatient Psychiatric	Prosthetic and Orthotic Devices and Appliances
Services for Individuals under 21 and over age 65	
Laboratory and X-rays	Rehabilitative Services: -occupational therapy -physical therapy -speech-language services
Medical Day Care Services	
Medical Supplies and Equipment	
Mental Health Services	
	Transportation for Medicaid-Covered Services

In addition to the services listed above and subject to the limitations imposed by federal law, the medical assistance program may also include any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of the Federal Department of Health and Human Services and approved by the Commissioner of the Department of Human Services.

Authorized Non-Legend Drugs **5-23-95**

Certain non-legend drugs or Over-the-Counter (OTC) drug products are covered by Medicaid when prescribed by a physician. These products include contraceptive devices and supplies, OTC family planning supplies, pharmaceutical inhalation devices, diabetic testing materials, insulin needles and syringes, insulin products, and antacids. For Medicaid beneficiaries under twenty-one years old, the additional non-legend drugs covered by Medicaid shall be limited to the following Specific Therapeutic Drug classes:

- Analgesics, salicylates (pain relievers);
- Analgesics/antipyretics, nonsalicylate (fever reducers);
- Antidiarrheals;
- Antiemetics (anti-nausea medicines);
- Antiflatulents (gas reducers);
- Antihistamines (allergy medicines);
- Antipruritics (itch relievers);
- Antitussives, non-narcotic (cough medicines);
- Cathartics;
- Cough and cold preparations;
- Emetics (nausea inducers);
- Expectorants;
- Hematinics (iron compounds);
- Iron replacement supplements;
- Laxatives;
- Multiple vitamin preparations;
- Pediatric vitamin preparations;
- Vitamins A, B, C, D, E, K, B1, B2, B12 preparations;
- Polymyxin and derivatives;
- Topical preparations, antibacterial;
- Topical antibiotics; and
- Topical anti-inflammatory preparations.

Only non-legend drug products manufactured by pharmaceutical companies in the Medicaid Drug Rebate program are covered by New Jersey Medicaid.

Garden State Health Plan (GUSH) beneficiaries are eligible to receive coverage for all non-legend drug products manufactured by pharmaceutical companies participating in the Medicaid Rebate program when properly authorized by a Physician Worker (CPM) or when prescribed by a physician authorized to prescribe medication based on a CPM referral.

General Exclusion **6-30-97**

The items listed here are general exclusion from New Jersey Medicaid coverage. There are certain additional specific exclusion and limitations which are detailed in the appropriate provider manual sections. Payment is not made for:

- Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;

- Any services or items furnished in connection with elective cosmetic procedures; NOTE: There are certain exceptions to this rule. A written certification of medical necessity and a treatment plan must be submitted by the physician to the Medical Local Office for consideration as prior authorization is required.

- Private duty nursing services (except for recipients under EPSDT);

- Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;

- Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the covered person claims or receives benefits there under;

- That part of any benefits which are covered or payable under any health, accident, or other insurance policy (including any benefits payable under the "New Jersey Automobile Reparation Act", PL. 1972, c.70), any other private or governmental health benefit system, or through any similar third party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund;

- Services or items furnished prior to or after the period for which the patient presents evidence of eligibility for coverage;

- Any services or items furnished for which the provider does not normally charge;

- Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;

- Services billed for which the corresponding health care records do not adequately document all required elements of the procedure described or procedure code utilized by the billing provider, as specified in the Provider Manual;

- Services or items provided primarily for the diagnosis and treatment of infertility, including sterilization reversals and related office visits; or

- Services provided outside the United States and its territories are not covered by the New Jersey Medicaid Program.

Prior Authorization Requirements for Services 6-30-97

Under the Medicaid Program, reimbursement for certain services requires providers to obtain prior authorization from the Program before a client can receive the service. Prior authorization is defined as formal written approval before services are rendered. Such approval is obtained by a provider through the Medical Assistance Customer Centers (MACC). Prior authorization requirements are described in each medical provider manual. A detailed prescription must be submitted with the provider request.

A list of services which require prior authorization is available to providers in current provider manuals/newsletters or through the MACC. The Local Office may contact the MACC in their county to obtain information regarding services which require prior authorization. See the list of MACCs at http://www.state.nj.us/humanservices/dmahs/info/resources/macc/MACC_Directory.pdf.

Claims Contractors **12-18-2000**

Medicaid has negotiated a contract with UNISYS Corporation to be the single fiscal agent for processing and payment of New Jersey Medicaid claims.

If a non-Medicaid provider is interested in pursuing a relationship with the New Jersey Medicaid Program, he/she can be referred to:

Provider Enrollment
UNISYS Corporation
P.O. Box 4804
Trenton, New Jersey 08650-4804
(Telephone #: 1-800-776-6334)

Medical Care Providers **5-23-95**

Medical services are rendered by providers to Medicaid recipients. The term "provider" refers to that individual, partnerships, association, corporation or other entity meeting applicable requirements and standards for participation in the New Jersey Medicaid Program.

Free Choice by Covered Person and by Provider 5-23-95

The concept of freedom of choice applies to both provider and recipient. An eligible person is free to choose providers of service who meet Program standards and who elect to participate. It is understood that when a provider has accepted an individual for care he will accept the Program's policies and reimbursement for all covered services and/or items which he provides or delivers during that period when, by mutual agreement, the recipient is under the provider's care. In this provision of professional services, it is considered automatic that the provider will be bound by the code of ethics governing his profession. The Medical Assistance Customer Center will assist covered persons in obtaining services if the eligible person cannot locate a provider.

Transportation Services **1-4-96**

Medicaid reimburses transportation services only when a Medicaid recipient is transported for the purposes of obtaining a Medicaid-covered service. The modes of transportation reimbursable include air and ground ambulance, invalid coach service and "lower mode" services. "Lower mode" services include taxi, train, bus, other public conveyances and can include mileage reimbursement. Authorization must be obtained before transportation services are rendered. Air ambulance, invalid coach services, and services to distant, out-of-state or unusual destinations require prior authorization from the Medical Assistance Customer Center.

Except in Essex and Hudson counties, the appropriate county welfare agency/board of social services arranges the lower mode transportation services. In Essex and Hudson Counties, the Essex County Medical Assistance Customer Center authorizes the service which is provided by an individual contracted provider. The toll free line for the service is 1-800-315-5278. In the remaining 19 counties the service is accessed by contacting the transportation coordinator/unit of the county welfare agency.

Reimbursement for Services **3-23-81**

The Medicaid program pays health care providers directly for services rendered. Medicaid patients in long term care facilities, skilled nursing, intermediate care, intermediate care/mental retardation and psychiatric hospitals are required to contribute their available income, after allowable deductions, toward the cost of care directly to the facilities.

Procedures for Providers Submitting Claim Forms to Receive Payment **3-23-81**

RESPONSIBILITY	ACTION REQUIRED
Provider	1. Complete a provider application form and receive approval from the Medicaid Program to become an eligible provider.
	2. Obtain prior authorization, if necessary.
	3. Provide service.
Provider Client, or Representative, Minor Child	4. Identify the availability of third party insurance. If available to the client, submit bill to third party insurance plan for payment. Receive payment from other insurance plan prior to submission of a Medicaid claim.
	5. Complete claim form.

	6. Review and sign claim form representatives in order of if a preference, are: parent, legal guardian, relative, friend, provider, representative of an institution providing care or support, representative of a government agency providing assistance. Relationship is indicated after a signature.
	7. Submit claim form to contractor within set time limits: • Inpatient claims within 12 months from date of discharge; • Outpatient home health service claims within 12 months from earliest date of service; and • All other claims within ninety days of the last service.
Claims Contractor	8. Issue payment, based on set reimbursement rates.
Provider	9. Receive and accept payment as payment in full.

Other Health Insurance Coverage 3-23-81

Medicaid payments are last payment benefits. The Program requires that all health and accident insurance benefits, including Medicare, Workmen's Compensation, and "No Fault Auto Insurance," shall be used first and to the fullest extent in meeting the medical needs of a Medicaid eligible person. Supplementary payment by Medicaid may occur when:

- The other coverage has been used to its fullest extent, but the bill is not satisfied; and
- The private insurance plan does not require the practitioner to accept its payment as payment in full; and
- The combined payment is no more than Medicaid's maximum rate.

Complaints about Quality of Services 2-5-88

Complaints regarding the quality of services rendered by health care providers through Medicaid are handled by the MACC. See the list of MACCs at http://www.state.nj.us/humanservices/dmahs/info/resources/macc/MACC_Directory.pdf.

Procedures for Filing Complaints About Quality of Services 11-20-2001

RESPONSIBILITY	ACTION REQUIRED
Worker/Client	1. Receive complaint about quality of service provided through Medicaid.

	2.Write letter to the Administrator of the MACC, specifying: • Name of client; • Problem; • Date of incident; • Date response is expected
	3. Contact MACC if response is not received on expected date.
	4. Send copies of letters to: Child and Family Health Division of Child Protection and Permanency Capital Center CC 903 50 East State Street Trenton, New Jersey 08625